Department of Justice Activities
Under the
Civil Rights of Institutionalized Persons Act
Fiscal Year 2008
Table of Contents

I. Introduction and Overview .................................................. 1

II. Filing of CRIPA Complaints/Resolution of Lawsuits and Investigations 4
   A. Cases Filed ........................................................................ 4
   B. Settlements in Cases Filed in Prior Fiscal Years ............... 8
   C. Out of Court Settlements Addressing Deficiencies
      Identified in CRIPA Investigation ..................................... 9
   D. Court Orders ...................................................................... 10

III. Prison Litigation Reform Act .............................................. 11

IV. Compliance Evaluations ..................................................... 11

V. Enforcement Activities ....................................................... 15

VI. Termination of CRIPA Consent Decrees and Partial Dismissal
    of Complaints ..................................................................... 16

VII. New CRIPA Investigations .................................................. 16

VIII. Findings Letters .................................................................. 18

IX. Investigation Closures ......................................................... 19

X. New Freedom Initiative ......................................................... 19

XI. Technical Assistance ............................................................ 22

XII. Responsiveness to Allegations of Illegal Conditions .......... 24

XIII. Juvenile Justice Activities .................................................. 25
I. Introduction and Overview

The Attorney General has authority to investigate conditions in public residential facilities¹ and to take appropriate action if a pattern or practice of unlawful conditions deprives persons confined in the facilities of their constitutional or federal statutory rights, pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997.² With respect to juvenile justice, the Department has concurrent jurisdiction to conduct investigations pursuant to the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141, and CRIPA. The Attorney General has delegated day-to-day responsibility for CRIPA activities to the Civil Rights Division and its Special Litigation Section.

As part of its overall civil rights law enforcement effort, the Department has prioritized vigorously enforcing the laws which protect the rights of institutionalized persons. According to Acting Assistant Attorney General of the Civil Rights Division, Grace Chung Becker,³ Thanks to the remarkable enforcement work of the Special Litigation Section, vulnerable members of our communities, whether living in nursing homes, in juvenile facilities, or other institutional settings, are ensured that their rights are equally protected under the law. The Division's vigorous enforcement of CRIPA creates systemic reform that benefits not only current but potentially generations of future residents of such facilities. "

¹ Institutions covered by CRIPA include nursing homes, mental health facilities, facilities for persons with developmental disabilities, residential schools for children with disabilities, jails, prisons, and juvenile justice facilities.

² CRIPA does not cover the federal statutory rights of persons in jails and prisons.

³ Grace Chung Becker served as Acting Assistant Attorney General from December 2007 through the end of Fiscal Year 2008.
The Division’s recent activities evidence its commitment to CRIPA enforcement. From January 20, 2001 through September 30, 2008, the Division opened 94 CRIPA investigations, issued 71 findings letters, filed 32 cases, and obtained 69 substantial agreements.

From May 1980, when CRIPA was enacted, through September 2008, the Division investigated conditions in 477 nursing homes, mental health facilities, centers for persons with developmental disabilities, residential schools for children with disabilities, jails, prisons, and juvenile justice facilities. As a result of the Department's CRIPA enforcement, thousands of persons residing in public institutions across our country no longer live in dire, often life-threatening, conditions.

At the end of Fiscal Year 2008, the Division was active in CRIPA matters and cases involving 211 facilities in 33 states, the Commonwealths of Puerto Rico and the Northern Mariana Islands, and the Territories of Guam and the Virgin Islands. The Division continued its investigations of 110 facilities, and monitored the implementation

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4 The Department has been unable to conduct an analysis of the impact of the actions instituted pursuant to CRIPA, including an estimate of the costs incurred by the states and other political subdivisions.

5 This figure does not include the Division’s monitoring of the District of Columbia community system for persons with developmental disabilities in Evans and United States v. Williams (D. D.C.), rev’d sub nom. United States v. Fenty (D. D.C.), a pre-CRIPA suit.

6 Fiscal Year 2008 began on October 1, 2007 and ended on September 30, 2008. This report is submitted to Congress to supplement the Attorney General's report on Fiscal Year 2008 Department activities by providing additional details about CRIPA actions during the Fiscal Year pursuant to 42 U.S.C. § 1997(f).
of consent decrees, settlement agreements, memoranda of understanding, and court orders involving 101 facilities. During the Fiscal Year, the Division, accompanied by expert consultants, conducted 135 tours of facilities to evaluate conditions and monitor compliance.

The Division filed six institutional lawsuits involving 13 facilities, closed three cases involving four facilities, and partially closed two cases involving four facilities during the Fiscal Year. The Division initiated 18 investigations of 32 facilities and issued ten findings letters regarding investigations of 11 facilities during the Fiscal Year. In addition, during Fiscal Year 2008, the Division closed four investigations of four facilities.

In keeping with the statutory requirements of CRIPA, the Division engaged in negotiations and conciliation efforts to resolve a number of CRIPA matters both before and after filing CRIPA cases. The Division maximized its impact and increased its efficiency by continuing to focus on multi-facility investigations and cases, obtaining widespread relief whenever possible. The Division also consulted with public officials and provided technical assistance to a substantial number of jurisdictions to assist in the correction of deficient conditions.

7 In addition, during the Fiscal Year, the Division monitored compliance with court orders that cover persons who previously resided in institutions, but who currently reside in community based residential settings in Indiana, Iowa, Puerto Rico, and Tennessee.

8 The settlement agreements (including consent decrees) and findings letters are available on the Division’s website at http://www.usdoj.gov/crt/split/index.html.
Lastly, pursuant to Section f(5) of CRIPA, the Division provides information regarding the progress made in each Federal institution (specifically from the Bureau of Prisons and the Department of Veterans Affairs) toward meeting existing promulgated standards for such institutions or constitutionally guaranteed minima. (See attached statements).

II. **Filing of CRIPA Complaints/Resolution of Lawsuits and Investigations**

A. Cases Filed

1. On February 1, 2008, the Division filed a Complaint in *United States v. Texas*, 7:08-CV-00038 (S.D. Tex. 2008)\(^9\) regarding conditions at the Evins Regional Juvenile Center, a state operated juvenile justice center in Edinburg, Texas. The Complaint alleged that the State engaged in unlawful patterns or practices at Evins, including the failure to protect youth from harm and undue risk of harm from staff assaults and youth-on-youth assaults. The Agreed Order, entered by the Court on May 5, 2008, requires the State to provide reasonably safe conditions at all times, staff training, and quality assurance monitoring. The Division continues to review compliance with the Agreed Order.

2. On February 28, 2008, the Division filed a Complaint and Settlement in *United States v. Santa Fe County, New Mexico*, 1:08-CV-00212 (D. N.M. 2008) regarding conditions and healthcare practices at Santa Fe County Adult Detention Center in Santa Fe, New Mexico. The Complaint alleged that the County failed to

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\(^9\) The Division initiated the investigation of the Evins juvenile facility pursuant to CRIPA and the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141; court filings were pursuant to 42 U.S.C. § 14141.
protect inmates from serious harm and undue risk of serious harm by failing to provide adequate medical and mental health services, and safe and sanitary living conditions. The Settlement Agreement, entered by the Court on April 30, 2008, requires the County to improve medical and mental health services for inmates as well as constitutionally required safe conditions of confinement. The Division continues to monitor compliance with the Settlement Agreement in this case.

3. On April 9, 2008, the Division filed a Complaint and Settlement Agreement in United States v. Marion County Superior Court, Indiana, 1:08-CV-0460-LJM-T (N.D. Ind. 2008)\textsuperscript{10} regarding healthcare services and conditions at Marion Superior Court Juvenile Detention Center (MSCJDC) in Indianapolis, Indiana. Specific allegations include the County’s failure to: provide MSCJDC residents with adequate protection from harm by other youth and self harm, abuse and unsafe conditions; utilize appropriate isolation practices; and provide adequate special education services to youth with disabilities. The Settlement Agreement, entered on April 11, 2008, requires improvements at MSCJDC to ensure reasonably safe conditions of confinement, including adequate numbers of trained staff, an effective behavior management program, appropriate suicide prevention and other mental health services, adequate fire safety, and special education and related services for youth with disabilities. The Division continues to monitor compliance with the Settlement Agreement.

\textsuperscript{10} The Division initiated the investigation of the Marion County juvenile facility pursuant to CRIPA and the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141; court filings were pursuant to 42 U.S.C. § 14141.
4. On May 16, 2008, the Division filed a Compliant and Settlement Agreement in United States v. Ohio, C2-08-0475 (S.D. Ohio 2008)\textsuperscript{11}, resolving its CRIPA investigation involving eight juvenile justice facilities, including: Circleville Juvenile Correctional Facility, Indian River Juvenile Correctional Facility, Cuyahoga Hills Juvenile Correctional Facility, Mohican Juvenile Correctional Facility, Ohio River Valley Juvenile Correctional Facility, Freedom Center, Scioto Juvenile Correctional Facility, and Marion Juvenile Correctional Facility. The Complaint alleged that the State failed to adequately protect youth from harm and caused undue risks of harm by failing to provide adequate medical, dental, and mental health services to youth; subjected youth to unwarranted uses of force and seclusion; and failed to provide adequate special education and related services to youth with disabilities. The Settlement Agreement, entered by the Court on June 24, 2008, requires the State to provide: adequately safe conditions; improved mental health, medical, and dental care; adequate grievance process and structured programming, and adequate special education and related services. The Agreement also provides for the appointment of a Monitor to oversee compliance. The Division continues to review progress towards compliance with the Agreement in the case.

5. On June 30, 2008, the Division filed a Complaint in United States v. Nebraska, 08-08CV271-RGK-DL (D. Neb. 2008) regarding conditions and practices at the Beatrice State Developmental Center in Beatrice, Nebraska. The Complaint alleged

\textsuperscript{11} The Division initiated the investigation of the Ohio juvenile facility pursuant to CRIPA and the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141; court filings were pursuant to 42 U.S.C. § 14141.
that the State failed to provide residents with adequate protection from abuse, neglect, and other harm; adequate training to protect residents’ liberty interests and freedom from undue restraints; and, adequate health care and mental health services. Further, the Complaint alleged that the State excluded Beatrice residents from participating in services in the most integrated setting appropriate to their needs, in violation of the Americans with Disabilities Act, 42 U.S.C. § 12101 et seq. The Consent Decree, entered by the Court on July 2, 2008, requires the State to provide conditions that include: zero tolerance for abuse and neglect; adequate levels of staff supervision; habilitative training and behavioral services; adequate health care and therapeutic services; freedom from unreasonable restraints; and adequate discharge planning services. The Consent Decree also provides for the appointment of an Independent Expert to monitor the State’s compliance with the Decree. The Division continues to review progress toward compliance in this case.

6. On September 4, 2008, the Division filed a Complaint and Settlement Agreement in United States v. Doyle, 08-C-0753 (E.D. Wis. 2008), regarding conditions of confinement at Taycheedah Correctional Institution in Fond Du Lac, Wisconsin. The Complaint alleges that the State failed to provide adequate mental health and healthcare services and safety to 600 female inmates who reside in the facility. The Agreement requires the State to improve mental health and medical services, including the provision of adequate treatment, documentation, and quality assurance. The Agreement appoints a Consultant to evaluate and report on compliance. The Division continues to review progress toward compliance with the Agreement in the case.
B. Settlements in Cases Filed in Prior Fiscal Years

1. On June 30, 2008, the Department filed a Modified Agreement in United States v. Georgia, 1-98-CV-836 (N.D. Ga. 1998) that sets forth the process for determining compliance with the 1998 Settlement Agreement, involving 30 Georgia juvenile justice facilities, regarding: medical and mental health services, and protection from harm. Because the facilities have attained compliance with the original Settlement Agreement on special education, investigation of child abuse, and quality improvement, the modification releases the State from further monitoring in those areas. The 2008 Agreement additionally provides for a Monitor to review progress toward compliance. The Division continues to review progress in this case.

2. On September 9, 2008, the Court in United States v. Oklahoma, 06-CV-673-GKF-FHM (N.D. Okla. 2006) entered a Settlement Agreement to resolve the litigation regarding youth confined to the L.E. Rader Center in Sand Springs, Oklahoma. The Agreement provides for: adequate protection from harm, prevention of suicide and self-harm, mental health services, and special education and related services for youth with disabilities. The Agreement further requires the State to provide: reasonably safe housing and supervision of youth; adequately training for staff in behavior management, use of de-escalation techniques, and crisis intervention; enforcement of policies regarding inappropriate relationships between staff and youth; and establishment of an

12 The Division initiated the investigation of the Oklahoma juvenile facility pursuant to CRIPA and the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141; court filings were pursuant to 42 U.S.C. § 14141.
adequate grievance system. The Division continues to monitor compliance with the Agreement in the case.

C. Out of Court Settlements Addressing Deficiencies Identified in CRIPA Investigations

1. On April 30, 2008, the Division entered into an Agreement with Garfield County, Oklahoma regarding conditions in the Garfield County Detention Center. In order to provide a reasonably safe environment at the Detention Center, the County agreed to provide adequate medical and mental health services, including suicide prevention; increase numbers of trained security staff to address inmate safety; establish an adequate grievance system; and, appropriately document and review any physical force used by staff. The Division continues to monitor compliance with the Agreement in this matter.

2. On June 13, 2008, the Division entered into an Agreement with the City and County of San Francisco, California regarding conditions at Laguna Honda Hospital and Rehabilitation Center, the largest nursing care facility in the United States. In addition to requiring improvements in protection from harm, health care, restraint usage, and meaningful activities to maximize the well being of individuals residing at Laguna Honda, the Agreement additionally requires adequate discharge planning, increased community-based placement alternatives, and adequate vocational and employment resources for residents. The Division continues to monitor progress toward compliance with the Agreement in this matter.

3. On July 21, 2008, the Division signed a Settlement Agreement with county officials to improve conditions at the Wilson County Jail in Lebanon, Tennessee. The
County agreed to take substantial remedial measures to improve medical services and provide a Health Authority to supervise all medical care rendered to inmates; to provide adequate mental health services; and to ensure a reasonably safe environment, including adequate staffing levels, appropriate use of force, improved classification and contraband management; and, adequate fire safety. The Division continues to monitor progress towards compliance with this Agreement.

D. Court Orders

1. On December 21, 2007, the Court in United States v. Terrell County, Georgia, 1:04-CV-76(WLS) (M.D. Ga. 2004) signed an order requiring that Terrell County Jail provide all Jail inmates by April 2009 with housing in a facility that meets minimum constitutional standards. The Court's order additionally requires adequate correctional, medical, and mental health services, including suicide prevention, as well as adequate environmental health and safety. The Division continues to monitor progress towards compliance in this case.

2. On April 30, 2008 and July 9, 2008, the Court in United States v. Mississippi, 3:03-cv-1354-HTW-JCS (S.D. Miss. 2003) issued orders to amend the 2005 Consent Decree to include the suicide prevention and the protection from harm action plans, respectively, for Columbia and Oakley Training Schools. In addition, the Court increased compliance oversight of the Consent Decree by appointing additional Monitors to review suicide prevention and protection from harm services, and extended the duration of the Consent Decree by one year. The Division continues to monitor progress towards compliance in this case.
III. **Prison Litigation Reform Act**

The Prison Litigation Reform Act (PLRA), 18 U.S.C. § 3626, which was enacted on April 26, 1996, covers prospective relief in prisons, jails, and juvenile justice facilities. The Division has defended the constitutionality of the PLRA and has incorporated the PLRA’s requirements in the remedies it seeks regarding improvements in correctional facilities. For example, the Consent Decree entered on November 7, 2007 in *United States v. Dallas County, Texas*, 3 07 CV1559-N (N.D. Tex.), is PLRA compliant in that it contains the requisite admission of liability and requires only the minimum remedial measures needed to correct constitutional violations in the areas of medical care, mental health care, and sanitation and environmental conditions.

IV. **Compliance Evaluations**

During Fiscal Year 2008, the Division monitored defendants' compliance with CRIPA consent decrees, settlement agreements, and court orders designed to remedy unlawful conditions in publicly operated facilities throughout the United States. These facilities are:


B. Facilities for persons with mental illness: Guam Adult Mental Health Unit (United States v. Territory of Guam, 91-00-20 (D. Guam 1991)); John Umsted Hospital, Dorothea Dix Hospital, Cherry Hospital, and Broughton Hospital, North Carolina (2005 Settlement); Vermont State Hospital (United States v. Vermont, 2:06-CV-143l (D.Vt. 2005)); Metropolitan State Hospital, Napa State Hospital, Atascadero State Hospital, and Patton State Hospital (United States v. California, 06-2667 GPS (M.D. Cal. 2006)); and St. Elizabeths Hospital, (United States v. District of Columbia, 1:07-CV-0089 (D. D.C. 2007)).

Center, Scioto Juvenile Correctional Facility, and Marian Juvenile Correctional Facility (United States v. Ohio, C2 08 0475 (S.D. Ohio 2008)).


G. Other Facilities: New Mexico School for the Blind and Visually Impaired (United States v. New Mexico, 99-602 MV (D. N.M. 1999)).

V. Enforcement Activities

During the Fiscal Year, the Division has aggressively pursued actions against recalcitrant jurisdictions to address their failure to achieve compliance with agreed-upon settlement remedies.

In January 2008, the Commonwealth of Puerto Rico sought to modify the Consent Decree in United States v. Puerto Rico (D. P. R. 9 4-2080 CCC (D. P.R. 1994)) by submitting an alternative staffing plan for the Court’s approval. Because the new plan did not adequately address the significant staff shortages at the juvenile facilities, which created dangerous conditions for the juveniles residing there, the Division objected to the Commonwealth’s plan. On April 28, 2008, the Division filed a Motion for Specific Performance and Supplemental Relief in order to enforce the Commonwealth’s compliance with the staffing requirements of the consent decree. The Court has not yet ruled on the Motion by the end of the Fiscal Year.
VI. Termi nation of CRIPA Consent Decrees and Partial Dismissals of Complaints

When jurisdictions comply with settlement agreements or court orders and correct unlawful conditions in an institution, the Division joins with defendants to dismiss the underlying action. During Fiscal Year 2008, the Division joined with defendants to seek dismissal of all claims regarding the New Mexico School for the Blind and Visually Impaired (United States v. New Mexico (D. N. Mex. 1998)); the Nassau County Detention Center (United States v. Nassau County, New York (E.D. N.Y. 2002)); Fort Wayne Developmental Center and Muscatatuck Developmental Center (United States v. Indiana (S.D. Ind. 2000)); and, the Essex County Juvenile Detention Center (United States v. Essex County, New Jersey (D. N.J. 1987)). The Division also closed actions regarding three juvenile justice centers, Centro de Tratamiento Social - Guaynabo, Rio Grande Tratamiento Social, and Centro de Evaluacion Residencial, after Puerto Rico voluntarily terminated those programs (United States v. Commonwealth of Puerto Rico (D. P.R. 1994)). Similarly, the Division closed its matter regarding the Saipan Immigration Detention Center (United States v. Commonwealth of the Northern Mariana Islands (D. N. Mar. I. 1999)) after the jurisdiction voluntarily closed the facility.

VII. New CRIPA Investigations

The Division initiated 18 CRIPA investigations during Fiscal Year 2008. These new investigations involved the following facilities:

- William F. Green State Veterans’ Nursing Home, Alabama;
- Delaware State Psychiatric Center, Delaware;
• Erie County Correctional Facility, New York;
  Erie County Holding Center, New York;
• Kings County Hospital Center, New York;
• New York Juvenile Facilities:
  Lansing Residential Center
  Louis Gossett, Jr. Residential Center
  Tryon Girls’ Center
  Tryon Residential Center
• Pendleton Juvenile Correctional Facility, Indiana;
• Indianapolis Juvenile Correctional Facility, Indiana;
• Orleans Parish Prison, Louisiana;
• Harris County Jail, Texas;
• Denton State School, Texas;
• Miami-Dade County Department of Correction, Florida;
• Rogers State Prison, Georgia;
• Rosewood Center, Maryland;
• Minnesota Veterans’ Home, Minnesota;
• Texas facilities for persons with developmental disabilities:
  Abilene State School
  Austin State School
  Brenham State School
  Corpus Christi State School
  El Paso State Center
Lufkin State School
Mexia State School
Richmond State School
Rio Grande State Center
San Angelo State School
San Antonio State School

- Central Virginia Training Center, Virginia;
- Ancora Psychiatric Center, New Jersey; and
- Lake County Jail, Indiana.

VIII. Findings Letters

During the Fiscal Year, the Division issued ten written findings letters\textsuperscript{13} regarding 11 facilities, setting forth the results of its investigations, pursuant to Section 4 of CRIPA, 42 U.S.C. § 1997b, including:

- Kings County Jail, Washington;
- Oregon State Hospital, Oregon;
- Tennessee State Veterans’ Homes
  Humboldt, Tennessee
  Murfreesboro, Tennessee;
- Beatrice State Developmental Center, Nebraska;
- Worcester County Jail, Massachusetts;
- C.M. Tucker Nursing Care Facility, South Carolina;

\textsuperscript{13} The full text of these findings letters may be found at the Division’s website at http://www.usdoj.gov/crt/split/index.html.
Georgia Regional Hospital - Atlanta, Georgia;
Cook County Jail, Illinois;
Oklahoma County Jail and Annex, Oklahoma, and
Northwest Habilitation Center, Missouri.

In these investigations, the Division made significant findings of constitutional deficiencies. As envisioned by Congress, enforcement of CRIPA continues to identify egregious and flagrant conditions that subjects residents of publicly operated institutions to grievous harm. 42 U.S.C. § 1997a (a).

IX. Investigation Closures

During the Fiscal Year, the Division closed investigations of four facilities. After thorough investigations, the Division determined that conditions had substantially improved at three facilities and closed the investigations, including: Charlotte Hall Veterans Home in Maryland, Nevada Youth Training Center in Nevada, and A. Holly Patterson Geriatric Center in New York.

X. New Freedom Initiative

The Division also enforces Title II of the Americans with Disabilities Act, 42 U.S.C. § 12131 et seq., and its implementing regulations 28 C.F.R. § 35.130(d), to ensure that public officials operating healthcare facilities are taking adequate steps to provide services to residents in the most integrated setting appropriate to their needs. In June 2001, President George W. Bush announced the New Freedom Initiative, which set as a high priority for this Administration efforts to remove barriers to community placement for persons with disabilities. The Executive Order, “Community-based Alternatives for
Individuals with Disabilities,” 14 emphasized that unjustified isolation or segregation of qualified individuals with disabilities in institutions is a form of prohibited discrimination, and that the United States seeks to ensure that America’s community-based programs effectively foster independence and participation in the community. During the Fiscal Year, as part of the mandate to fully enforce Title II of the Americans with Disabilities Act, the Division took steps to secure increased access to residential, day, and vocational services where appropriate in the following facilities:

- Woodbridge Developmental Center, New Jersey;
- New Lisbon Developmental Center, New Jersey;
- Connecticut Valley Hospital, Connecticut;
- Lanterman Developmental Center, California;
- Laguna Honda Hospital and Rehabilitation Center, California;
- Atascadero State Hospital, California;
- Patton State Hospital, California;
- Metropolitan State Hospital, California;
- Napa State Hospital, California;
- Reginald P. White Nursing Facility, Mississippi;
- Glenwood and Woodward Resource Centers, Iowa;
- Oakwood Community Center, Kentucky;
- Mercer Geriatric Center, New Jersey;
- Lubbock State School, Texas;

• Ft. Bayard Medical Center, New Mexico;
• St. Elizabeths Hospital, District of Columbia;
• Tennessee State Veterans’ Homes;
• Clyde L. Choate Developmental Center, Illinois;
• Georgia mental health facilities:
  Georgia Regional Hospital - Atlanta
  Georgia Regional Hospital - Savannah
  Northwest Georgia Regional Hospital
  Central State Hospital
  Southwest State Hospital
  West Central Georgia Regional Hospital
  East Central Georgia Regional Hospital;
• Beatrice State Developmental Center, Nebraska;
• Bellefontaine Developmental Center, Missouri;
• Howe Developmental Center, Illinois;
• William F. Green State Veterans’ Home, Alabama;
• Delaware State Psychiatric Center, Delaware;
• Kings County Psychiatric Center, New York;
• Denton State School, Texas;
• Rosewood Center, Maryland;
• Minnesota Veterans’ Home, Minnesota;
• Texas facilities for persons with developmental disabilities, including:
  Abilene State School
Austin State School
Brenham State School
Corpus Christi State School
El Paso State Center
Lufkin State School
Mexia State School
Richmond State School
Rio Grande State Center
San Angelo State School
San Antonio State School;

Central Virginia Training School, Virginia; and
Ancora Psychiatric Center, New Jersey.

In the Fiscal Year, the Division monitored community placements or the community systems for persons with developmental disabilities in a number of states, including the District of Columbia (in a pre-CRIPA lawsuit), Indiana, Iowa, Puerto Rico, and Tennessee.

XI. **Technical Assistance**

Where federal financial, technical, or other assistance is available to help jurisdictions correct deficiencies, the Division advises responsible public officials of the availability of such aid and arranges for assistance, where appropriate. The Division also provides technical assistance largely through the information provided to jurisdictions by the Division’s expert consultants. After the expert consultants complete on-site visits and program reviews of the subject facility, they prepare detailed reports of
their findings and recommendations that provide important information to the facilities on deficient areas and possible remedies to address such deficiencies. The Division routinely provides such reports to cooperative jurisdictions. In addition, during the course of investigatory tours, the Division’s expert consultants provide helpful information to jurisdictions regarding specific aspects of their programs at no costs to the local or state government. These reports permit early intervention by local jurisdictions to remedy highlighted issues before a Findings Letter is forwarded.

In Fiscal Year 2008, the Division provided technical assistance in the process of enforcing CRIPA. For example, in United States v. Ohio, C2-08-0475 (S.D. Ohio 2008), the Division provided its juvenile corrections expert’s assistance to Ohio officials regarding the importance of accountability and outcome measures in the master plan for improvements required by the Settlement Agreement at eight juvenile facilities. In United States v. Indiana, IP 00-1991CB/S (S.D. Ind. 2000), the Division and the State jointly sponsored training sessions on health care coordination and risk management systems for protecting persons with developmental disabilities who live in community placements. In United States v. New Mexico, CV-07-470-WJ/DJS (D. N. Mex 2007), the Division’s nurse consultant provided on site technical assistance to Ft. Bayard Medical Center’s nursing staff regarding assessment of residents’ nursing care needs and health care planning. In our CRIPA matter concerning the Los Angeles County Jail (Settlement Agreement, 2002), the Division provided its consultants in mental health services to the Sheriff’s Office to provide technical assistance regarding the women’s mental health program.
In addition, to ensure timely and efficient compliance with settlement agreements, the Division issued numerous post-tour compliance assessments letters (and in some cases emergency letters identifying emergent conditions) to apprise jurisdictions of their compliance status. These letters routinely contain technical assistance and best practices recommendations.

XII. **Responsiveness to Allegations of Illegal Conditions**

During Fiscal Year 2008, the Division reviewed allegations of unlawful conditions of confinement in public facilities from a number of sources, including individuals who live at the facilities, relatives of persons living in facilities, former staff of facilities, advocates, concerned citizens, media reports, and referrals from within the Division and other federal agencies. The Division received over 7,000 CRIPA-related citizen letters and hundreds of CRIPA-related telephone complaints during the Fiscal Year. In addition, the Division responded to nearly 95 CRIPA-related inquiries from Congress and the White House.

The Division prioritized these allegations by focusing on facilities where allegations revealed systemic, serious deficiencies. In particular, with regard to facilities for persons with mental illness or developmental disabilities and nursing homes, the Division focused on allegations of abuse and neglect; adequacy of medical and mental health care; use of restraints and seclusion. Consistent with the requirements of Title II of the Americans with Disabilities Act and its implementing regulations, 42 U.S. C. §§ 12132 et seq.; 28 C.F.R. § 35.130(d), the Division also ensured that facilities provided services to institutionalized persons in the most integrated setting appropriate to meet their needs. Similarly, with regard to its work in juvenile justice facilities, the Division
focused on allegations of abuse, adequacy of mental health and medical care, and provision of adequate rehabilitation and education – including special education services. Finally, in relation to jails and prisons, the Division placed emphasis on allegations of abuse including sexual abuse, adequacy of medical care and psychiatric services, and grossly unsanitary and other unsafe conditions.

XIII. Juvenile Justice Activities

The welfare of our nation’s youth confined in juvenile justice facilities has been a high priority for the Division. During Fiscal Year 2008, there were three new investigations initiated, involving four facilities in New York and two facilities in Indiana; two new cases with Agreements regarding individual juvenile facilities in Texas and Indiana; as well as a third case and Agreement involving eight juvenile facilities in Ohio; During the Fiscal Year, the Division finalized an Agreement that settled a 2006 case regarding a juvenile facility in Oklahoma, and amended a 2005 Complaint and Settlement Agreement to add a juvenile justice facility in Maryland. For the period from January 2001 through September 2008, the Administration has authorized 24 investigations of 48 juvenile justice facilities, issued 18 findings letters regarding 27 facilities, and obtained eighteen substantial agreements. For investigations alone, this represents a greater than 100 percent increase in investigations than were authorized in the preceding seven and one half years.